MOUNT NITTANY PHYSICIAN GROUP

Pediatric Patient Questionnaire

Patient Name: _____ Date of Birth: _____

Pharmacy
Retail: _____
Mail Order:_____

Preferred Method of Reminder Communication
I would like to receive reminder communication via:
☐Patient portal ☐Cell phone ☐Home phone
☐Mail ☐Work phone

Other than needing glasses or contacts, does the parent/guardian have any visual impairment affecting reading? ☐Yes☐No
Does the parent/guardian have any vision/hearing impairment? ☐ YES☐ NO
Explain: _____

HEALTH CARE TEAM: Please list other health care providers that your child may see (example: Cardiologist)

Name	Specialty

Child's birth weight (if under 1 year old) _____lb. _____oz

ACTIVE PROBLEMS/PAST MEDICAL HISTORY
Does your child currently have any of the following medical problems? Place "X" in **ACTIVE** Problem column.
Has your child had any of the following medical problems in the past? Place "X" in **PAST** Problem column.

	Active Problem	Past Problem		Active Problem	Past Problem		Active Problem	Past Problem
Acid Reflux	☐	☐	**Depression**	☐	☐	**Hyperthyroidism**	☐	☐
Anemia	☐	☐	**Developmental Delay**	☐	☐	**Hypothyroidism**	☐	☐
Anxiety	☐	☐	**Diabetes**	☐	☐	**Learning disability**	☐	☐
Arthritis	☐	☐	**Digestive Problem**	☐	☐	**Neuromuscular Disorder**	☐	☐
Asthma	☐	☐	**Eating Disorder**	☐	☐	**Overweight**	☐	☐
Autism Spectrum	☐	☐	**Genetic Disorder**	☐	NA	**Prematurity** Weeks gestation_____	☐	☐
Bleeding Disorder	☐	☐	**Head Injury**	☐	☐	**Seizure**	☐	☐
Breech Birth	NA	☐	**Headaches**	☐	☐	**Skin disorder**	☐	☐
Cancer _____	☐	☐	**Hearing Difficulty**	☐	☐	**Tuberculosis**	☐	☐
Childhood Behavior Problems	☐	☐	**Hospitalized** (1+ nights other than routine normal newborn stay)	NA	☐	**Urinary Tract Infection**	☐	☐
Congenital Heart Defect	☐	☐	**History of ear infections**	☐	☐	**Vision Problem**	☐	☐
Cystic Fibrosis	☐	NA	**Hyperlipidemia** (High cholesterol)	☐	☐			
Dental Cavities	☐	☐	**Hypertension** (High Blood Pressure)	☐	☐			

Has your child had any other serious medical problems not listed previously? ☐ YES ☐ NO
If YES, please list: _____

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PAST SURGICAL HISTORY

☐ *No history of prior surgery

Has your child had any of the following surgical procedures, ***include year if known:***

Adenoids removed ☐ Yes ☐ No Year_____ Elective Circumcision ☐ Yes ☐ No Year_____

Appendix removed ☐ Yes ☐ No Year_____ Hernia repair ☐ Yes ☐ No Year_____

Ear Tubes Inserted ☐ Yes ☐ No Year_____ Tonsils removed ☐ Yes ☐ No Year_____

List any other ***operations or surgeries*** your child has ever had, ***including year if known***:

Type of Surgery	Year

FAMILY HISTORY

Is there any of the following in your child's immediate family? Check all that apply

☐ Patient is Adopted

	Mother	Father	Brother	Sister	Other:
Family History Unknown	☐	☐	☐	☐	☐
Alcohol Abuse	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐
Cancer					
• _____	☐	☐	☐	☐	☐
• _____	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Drug Abuse	☐	☐	☐	☐	☐
Celiac Disease	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐	☐
Hip Dysplasia	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐
Died from heart disease before age 50	☐	☐	☐	☐	☐
Sudden Infant Death Syndrome	NA	NA	☐	☐	☐
Other:	☐	☐	☐	☐	☐

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Immunizations: We require a copy of your child's immunization record.

SOCIAL HISTORY

For children under age 5, who primarily watches your child during the day? Check all that apply:

☐Parent/Guardian ☐Daycare Center/Home Daycare ☐ Grandparent or other relative ☐ Babysitter

☐Other: _____

Dental Care

*Does your child have a dental checkup at least yearly? ☐YES ☐NO

Living Situation: Select which best describes your child's living situation. Check all that apply.

☐ Lives in group home ☐ Lives with father (single parent) ☐ Lives with foster parents ☐ Lives with friend ☐ Lives with grandparent(s) ☐ Lives with mother (single parent)	☐ Lives with parents in same household ☐ Lives with parents who live in different households ☐ Lives with relatives ☐ Other: _____

Does anyone that lives in the home smoke either inside or outside the home? ☐Yes ☐No

ALLERGIES

Does your child have any allergies? ☐YES ☐NO

If YES, please list:

Name	Type of Reaction

Please List all MEDICATIONS your child is presently taking. Please include prescriptions, over the counter, vitamins, herbal and/or other supplements:

Name of Medication	**Strength (Ex 50 mg)**	**Directions (Ex. 1 pill twice daily)**	**Why do you take this medication?**	**Who prescribed this medication?**
ONLY COMPLETE THIS SECTION IF YOUR CHILD IS A NEW PATIENT				

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____

Patient Name: _____ Date of Birth: _____

PLEASE HAVE THE PATIENT WHO IS 13 AND OLDER COMPLETE THIS PAGE

Smoking History (Check one):

☐ Current smoker How many cigarettes per day? _____
☐ Former smoker When did you quit? _____
☐ Never a smoker
☐ Other _____

Smokeless Tobacco History (Check one):

☐ Never used smokeless tobacco
☐ Former user of smokeless tobacco When did you quit? _____
☐ Smokeless tobacco use What type of smokeless tobacco? _____

Alcohol Usage (check one):

☐ Alcohol Use
☐ No Alcohol Use

Illicit Drug Use–(check one):

☐ Current drug use
☐ History of drug use
☐ No drug use What types of drugs? _____

Patient/Representative Signature _____ Date: _____

Person who completed form if patient unable_____